# Summary of Questions from CEW Clinic Lunch & Learn sessions

## April 2022

| Frequently Asked Questions | Answers |
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| **Which patients should I refer? What is the criteria for referral, assessment and interventions?** | We will be initially taking patients with the highest need with established health complications.<br>• Severe obesity<br>• Obesity-related poor physical health (eg type 2 diabetes, sleep apnoea requiring ventilation, NAFLD with fibrosis)<br>• Engaged and wants support<br>• Engaged local/specialist team |
| **What are the exclusion criteria?** | Exclusion criteria include a disengaged family and/or an untreated significant mental health problem. |
| **Can I refer children with neurodiversity?** | Neurodiversity will not be an exclusion criterion, but we will be initially taking patients with the highest need, with established health complications as the main criteria. |
| **Can I refer children with Type 1 Diabetes?** | We will take on any patients who meet the above criteria. There aren't as many Type 1 diabetics who are obese, but those who are with complications that aren't responding to standard care can be referred. |
| **What is the upper age limit?** | The service will take children from aged 2 years to 18 years (within reason as we would probably not take on a patient who turns 18 within the next month or so). The referral form has all this information. |
| **When do you start accepting referrals?** | Referrals are open from 1st April 2022. |
| **Will the service accept CYP with Special Educational needs (SEND)? Would they meet criteria for assessment and interventions?** | This is an area that is often very tricky particularly because of the difficulty in providing the support required to help parents manage the behavioural difficulties that inadvertently arise when lifestyle changes are attempted.<br><br>These young people need to have support locally for this (e.g. from the local Neurodiversity/special school multidisciplinary team (MDT) to help support the interventions that we will provide. This is why it is crucial that local services/teams already involved continue to be involved, and may even need to intensify support for a period of time when changes are being made. |
| **Will there be the opportunity to share good practice, or to contribute to this service development?** | Absolutely - there is also the London Childhood Obesity Clinical Network, which meets every 2-3 months. If you're interested, please email england.cyptransformationldn@nhs.net and we can invite you to join the next meeting. |
| **Would you accept referrals from Kent/Surrey/ Sussex if patients are able to travel into London?** | This is only for London patients but Kent Surry and Sussex and East of England will be having their own service. Details about other CEW clinics outside London can be found within the slide pack. |

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| **Do you see young people diagnosed with Binge Eating Disorder?** | Yes, but they need to already be under an appropriate team to manage the Binge Eating Disorder (usually the local community eating disorder service) as the CEW clinic is not set up to treat Binge Eating Disorder directly (although we aim to work collaboratively with their local eating disorder team to ensure that the treatment plan is cohesive. |
| **Do you provide pharmacology as part of your treatment?** | Our multi-disciplinary team will include:<br>• Consultant Obesity Specialist Leads<br>• Clinical Nurse specialists<br>• Clinical Psychologists<br>• Family Therapist<br>• Assistant Psychologists<br>• Senior Dieticians<br>• Family Support Workers<br>• Clinic coordinator /admin manager<br>• Exercise practitioner<br>• Clinical fellow |
| **Will the intervention last a year?** | Currently, most clinics are aiming for a limited 1 year intervention, but we will be following-up outcomes after discharge as well to review if the interventions result in sustainable change. |
| **Do the young people stay open and get seen by CAMHS or other services alongside CEW?** | Yes, please! CEW clinics are not the magic wand that will cure all issues and we need to work together with ALL services involved in the young person's care to provide the holistic support required to overcome the multiple factors that will have contributed to and are perpetuating the obesity. This is not possible without the ongoing care from all other services looking after the young person. |
| **Some children have high BMI >45 and no health complications - can we refer?** | Initially patients need to fit the above criteria and have complications, as capacity is currently at 100 patients per CEW clinic centre (East and West – 100 at UCL/GOSH and 100 between King's and Bart's). |
| **Will you then map local services for example adult T3 services to use for parents and onward referral?** | This is already a conversation that is taking place for multiple reasons – we already have links to our local adult obesity services for transition but we are also aiming to work together with adult services to align our messages particularly for families where adults and young people may be under obesity services, to ensure there isn't conflicting advice that may further confuse things. |
| **If we've done all the baseline management and not got anywhere, where do we send for Bariatric surgery as King's will not cover our boroughs anymore?** | Paediatric bariatric surgery services are likely to be looked at nationally in the near future, so watch this space. If the patients fulfil the CEW clinic criteria, they can be referred to us instead to try to help manage the obesity through non-surgical means. |

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| **If a family lives far away from their assigned CEW clinic, will there be transport provided and/or reimbursement for transport?** | If you are concerned about transportation to the CEW clinic, you may choose to request the established hospital transport services, details found on their websites. To access these services you typically have to prove you are in the eligible income bracket and/or have another need. |
| **Is 100 patients a realistic target?** | The target has been set nationally as this is a pilot. 100 patients for each of the 2 London CEW Clinic centres. For the East London centre, King's and Bart's will be aiming to take approximately 50 patients each to try to provide equity of service. |
| **We don't have a weight management service in Lewisham, but we do receive a great number of referrals. These patients haven't been seen anywhere and have some co-morbidities. Can I refer directly to your service? I am a Paeds dietician.** | Patients do not need to be under a weight management service already if there is no provision for one in your local are (as is the case in many boroughs), and can be referred so long as they meet the above criteria (severe obesity with established significant comorbidity and willingness to engage).<br><br>We do ask that there is already some attempt at managing the obesity in the first instance (through general healthy lifestyle advice, etc.) as due to the limited number of patients we are able to take on, we are trying to focus on those with the most need who may not have responded to first line management. |
| **Who can refer? Does it have to be a consultant?** | Anyone can refer, not just consultants. We recommend that the whole MDT team discusses whether or not CEW is an appropriate service for the individual patient. |
| **Will the CEW service accept referrals from GPs?** | Yes, if they complete the referral form. |
| **I understand the need for engaged families, but what is the plan for those who don't want to engage? e.g. safeguarding referrals?** | Unfortunately, the CEW clinics are not the answer to all childhood obesity issues and willingness to engage is a prerequisite for our service, given that the treatment relies on engagement from the young person and family. Those who are not ready to engage will need to have the issues underlying the disengagement addressed first before they would benefit from the CEW clinics.<br><br>We would not reject referrals just because they are on a child protection plan (CPP) or child in need (CIN) plan, so long as it is clear that the young person and family are willing to engage with the programme. |
| **How often will patients' goals be reviewed?** | The family support worker will review every three months. |
| **What is the approach towards treating these patients once they have been** | Lifestyle changes, pushing a low calorie/low carbohydrate diet and consideration of Liraglutide.<br>A large component of our treatment plans will involve education and motivational work, as well as understanding factors within the individual's life that have been contributing to and perpetuating the obesity or blocking the |

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| **onboarded with you?** | way to a healthier lifestyle, and working together to remove or reduce these factors. |
| **Do you have a service leaflet you could send out?** | Yes. This will be shared with patients and will be available on the Future NHS site. |
| **Which platform will CEW clinics be using to feedback on once you have collated the data gathered after one year?** | There could be a further series of Lunch and Learn webinars organised to update. We will also share at the childhood obesity network meetings and via newsletter |
| **What if I live closer to a different clinic than I am assigned? I.e. Croydon is right next to Kings but as things stand, I have to travel to UCLH.** | Unfortunately, since it is a pilot programme, this is how the split will work for now. As we gather more data, this might change but for now these criteria are quite strict. If you are worried about travel costs to get to the clinic, see above. We will look at other ways of engaging once the initial assessment has been undertaken. |
| **Will you run a mental health service?** | Whilst we are not primarily a mental health service, we will support the patients to explore these needs and get appropriate mental health or psychological support for mental health comorbidities that may be identified during the course of assessment and treatment. |
| **How does the model align child and adult obesity care? Presumably we need a whole family approach.** | We haven't explored this yet, this but is a great idea to link multiple members of the same family if they have obesity too. We are exploring aligning adult and paediatric services as mentioned above, to try to provide a whole family approach and a joined-up message. |
| **What outcomes will you be looking at in a year's time?** | There is a list of primary outcomes that has been specified by NHSE that will help us better understand childhood obesity and its comorbidities as well as looking at effectiveness of our treatment plans (from the different aspects including physical, emotional and mental health) and we also plan to follow-up at an interval (probably 6 months initially) after completion of treatment to determine if results were sustained. |
| **What is the plan for families that won't engage?** | We plan to start with families that are willing to engage and then expand the service. They may need to stay under the care of their own local teams and consideration of referral to safeguarding teams. |
| **In addition to these webinars, how else are you promoting this service?** | On websites, with North and South Thames Paediatric networks, please do share this information with colleagues to help spread the word. Through the ICS children and young peoples leads. |
| **Some patients can have deranged LFTs without any symptoms. What is the threshold for investigation?** | Type 2 will usually present with symptoms. Fasting bloods can be taken or may be able to accept without bloods. NICE guidance states 'consider' investigation.<br><br>You may want to consider investigations for comorbidities with BMIs in the severely obese category (>99.6 centile). |

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| **For the family support worker role – is there any potential for outreach into the service?** | Each clinic may have a slightly different model, which includes some form of outreach such as through children's centres, youth centres as well as through virtual sessions and group work. |
| **Would the CEW service consider sleep studies?** | Yes |
| **Should OSA patients be referred to ENT first or to CEW?** | This will depend on the clinical assessment as someone with Grade 3-4 tonsils would probably benefit from an ENT review alongside referral to CEW (particularly if they have OSA needing NIV/CPAP) |
| **Could we have the toolkit mentioned by Andrew Marshall?** | Healthy Weight toolkit from Oxfordshire |